

# Healthcare Coalitions

## Case Studies & Examples

### Michigan Healthcare Coalitions

The HPP is supported through eight Healthcare Coalitions. These coalitions work with local partners within each region to prepare hospitals, emergency medical services, and supporting healthcare organizations to deliver coordinated and effective care to victims of terrorism and other public health/healthcare emergencies. Each region maintains one full-time regional coordinator and one part-time medical director. The medical director is employed or contracted through a Medical Control Authority (MCA)

#### **More information:**

- [http://www.michigan.gov/documents/mdch/regional\\_bt\\_contacts\\_map\\_321591\\_7.pdf](http://www.michigan.gov/documents/mdch/regional_bt_contacts_map_321591_7.pdf)
- [http://www.michigan.gov/mdch/0,1607,7-132-2946\\_5093\\_28508-132260--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2946_5093_28508-132260--,00.html).

### Chicago Health System Coalition for Preparedness and Response (CHSCPR)

CDPH receives funding from the U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response (ASPR), Hospital Preparedness Program (HPP). The funding provided through the HPP is for activities that include, but are not limited to, exercising and improving preparedness plans for all-hazards emergencies, including pandemic influenza, increasing the ability of healthcare systems to provide needed beds, engage with other responders through interoperable communication systems, track bed and resource availability using electronic systems, develop systems for healthcare volunteers, protect healthcare workers with proper equipment, provide decontamination to affected patients, enable partnerships/coalitions, educate and train healthcare workers, enhance fatality management and healthcare system evacuation/shelter in place plans, and coordinate regional exercises.

CDPH and its healthcare system partners conduct the work of the HPP via the Chicago Health System Coalition for Preparedness and Response (CHSCPR), which is made up of hospitals, public health, emergency medical services (EMS), long-term care and others. The Coalition structure provides a functioning process that is inclusive of the needs of all partners within the Chicago healthcare delivery system. The CHSCPR has organized its work around a number of sub-committees, most of which mirror the ASPR's Level 1 and Level 2 sub-capabilities. Each committee is chaired/co-chaired by representatives from hospitals, EMS or other partner agencies and each committee has been working to ensure that work is undertaken toward the goal of achieving fulfillment of the ASPR requirements and expectations relevant to each specific committee.

#### **More Information:**

- [http://www.cityofchicago.org/city/en/depts/cdph/supp\\_info/public\\_health\\_preparedness/hospital\\_and\\_healthcaresystempreparednessprogram.html](http://www.cityofchicago.org/city/en/depts/cdph/supp_info/public_health_preparedness/hospital_and_healthcaresystempreparednessprogram.html)

### Washington State Department of Health Region 1 Health Care Coalition

The North Region EMS and Trauma Care Council in conjunction with the Region 1 Public Health and Hospital Emergency Preparedness and Response Committee have moved into their second phase of preparedness planning. Over the past couple of years, we have focused exclusively on hospital preparedness in Region 1

(Island, San Juan, Skagit, Snohomish and Whatcom Counties). Beginning this year, we will develop a Healthcare Coalition which will move our preparedness efforts from the hospitals to the overall healthcare community.

Our goal is to have a cohesive group of medical organizations that can provide seamless medical care for the citizens of our Region during an emergency. Through planning, preparation and training, we will develop a comprehensive system that will be able to handle any type of disaster that may strike our area. HRSA Goals for Healthcare Coalitions:

"Improves the capability of local and regional health care systems to:

- Manage mass casualty events
- Integrate preparedness activities across disciplines and agencies
- Enhance medical surge capacity and capability
- Foster development of MOUs/MOAs"

**More Information:**

- <http://www.northregionems.com/Preparedness/Region%201%20Healthcare%20Coalition.pdf>

## Northern Virginia Health Care Coalition Overview

Northern Virginia hospitals and their coalition partners, including non-hospital providers, Emergency Management, Fire, EMS, Law Enforcement and Public Health, work diligently in their efforts to assure a coordinated response to a wide range of emergency events. Adequate preparation by healthcare organizations, in collaboration with their community partners, is critical to safeguarding the lives of the residents and workers of Northern Virginia. Planning and pre-event coordination takes place under the auspices of the Northern Virginia Emergency Response System (NVERS), formerly Metropolitan Medical Response System (MMRS), of which Northern Virginia hospitals are an integral part.

The Northern Virginia Hospital Alliance sets forth organizational and operational goals for coordinating and distributing resources in response to, and recovery from, any type of catastrophic disaster or large-scale emergency situation. These goals embrace the "all hazards" concept. Plans assign broad responsibilities to participating agencies and support organizations for disaster mitigation, preparedness, response, and recovery. They also define the relationship between the hospitals and Regional Hospital Coordinating Centers (RHCC) to enhance and improve coordination and response capabilities of hospitals during an emergency or disaster within the region. The regional system is intended to be capable of a sustained response for a period of 72 hours without federal assistance and includes provisions for:

- Notifying hospitals and other healthcare facilities that an incident has occurred;
- Protecting hospitals and other healthcare facilities by sharing information regarding environmental or patient-source contamination;
- Obtaining pharmaceuticals and other medical equipment in a timely manner;
- Obtaining essential non-clinical supplies in a timely manner;
- Transferring and moving patients in a coordinated manner;
- Coordinating with local EMS incident command to manage the distribution of patients from the scene of an MCI to area hospitals;
- Coordinating with local and regional public health and emergency management to ensure ongoing situational awareness and information sharing; and,
- Management and distribution of regionally-stockpiled assets (ventilators, supplies, IV fluid, etc.).

**More Information:**

- <http://www.vahs.virginia.gov/Agencies/SCP/docs/SCP-meeting-10272010/Northern-Virginia-Overview-for-OCP.pdf>

## Kentucky Healthcare Coalitions from Response to Recovery

On March 2nd, 2012, numerous tornadoes swept across eastern Kentucky. There were disasters declared in 12 counties. There were 23 fatalities and more than 200 injuries. In West Liberty (Morgan County), the critical access hospital, Morgan County ARH (Appalachian Regional Healthcare), was severely damaged by the tornadoes. This hospital was part of the Kentucky Region 8 Healthcare Planning Coalition (HPC).

No patients or staff members were injured in the twister but the second-floor windows were blown out, the roof was destroyed, exterior doors were torn off their hinges and cars were demolished in the parking lot. Damages totaled nearly \$4 million. The hospital's emergency room never closed, but damage to the second floor of the hospital prevented inpatient admissions for several months. Patient rooms were demolished and there was no electricity.

### Maintaining Essential Services - Immediate Healthcare Coalition Response

During Kentucky ESF 8 preparedness planning, emergency support trailers were strategically placed in each of the healthcare planning coalition regions. These mobile medical assets included emergency medical supplies and generators so that facilities could maintain essential healthcare delivery services during a disaster. However, tornadoes don't necessarily read even the best laid disaster plans of a jurisdiction and many of the nearby assets in Region 8 and 9 were destroyed.

Even though response assets were destroyed, redundant planning and good coordination between Kentucky ESF 8 and their healthcare coalitions enabled other resources to be mobilized and deployed to assist Morgan County ARH.



### ESF 8 – Healthcare Coalition Resource Management

The first HPP Region 8 resources were moved into West Liberty within the first hour of the event. A representative from the Kentucky Region 8 Healthcare Planning Coalition stated: "Decisions we made months ago as a group made a real difference during this disaster". This planning made it possible for the following assets to be rapidly deployed:

- An HPP Region 8 Mass Casualty Trailer was deployed from Fleming EMS to ground zero West Liberty (Fleming County is two counties away to the NW)
- Portable Oxygen Generators were sent to Morgan County ARH (POG System from Rowan County with Booster from Fleming County)
- A 125 KW Generator Trailer from Rowan County was deployed to provide power to the West Liberty Nursing Home (Rowan County is Morgan County's neighbor to the NW)
- Two HPP trailers were deployed to West Liberty from Gateway Health Department (about 45 miles away in Bath County)



### Supporting Critical Services

Additional regional and state HPP equipment and generators were deployed and enabled ARH Morgan County to keep their Emergency Department open, even though the rest of the hospital was evacuated.

### Transitioning into Recovery

The generators and other equipment that were provided to ensure immediate post-incident support enabled the hospital to bring back online X-ray, lab, pharmacy, and clinic services. The resource support continued as Morgan County ARH began to rebuild the rest of the hospital.



### Public Health Support

As immediate healthcare recovery was occurring, assets in the Healthcare Planning Coalition regions were also used to provide Public Health support. A Mobile Pharmacy Unit, purchased with HPP funds, was used as temporary office for the Morgan County Health Department. With this asset, the county was able to provide services for WIC, Immunization (tetanus and flu), Family planning services, and Environmental Health services. This type of support is just one indicator of the strong bond between public health and healthcare in the State of Kentucky

### Recovery Complete

The coordination and cooperation of the Healthcare Planning Coalitions in Kentucky were instrumental in assisting one of their own through a disaster into recovery. They did not rebuild the hospital but provided resources and assistance so that the hospital could continue to do business and provide care to the community. This is the essence of what healthcare coalitions do.





## REGION 3 HEALTHCARE PREPAREDNESS COALITION CHARTER

*(Revised & Approved 6/12)*

### MISSION STATEMENT

**By promoting intra-regional cooperation and sharing of resources, the Region 3 Healthcare Preparedness Coalition will support local healthcare organizations to jointly respond to man-made or natural emergencies.**

### COALITION MEMBERSHIP

The Coalition is an inclusive body open to all organizations that provide or support health services within Grays Harbor, Lewis, Mason, Pacific and Thurston counties that wish to work collaboratively on emergency preparedness and response activities.

Voting membership of the organization is based upon participation and includes the following criteria:

1. Attendance by a representative of the organization at two (2) of the last three (3) meetings;
2. Votes are organization-based; each healthcare organization is entitled to one (1) vote, provided the criteria above are met.

### ORGANIZATION/STRUCTURE

The Coalition will have:

1. An executive director for day to day operations;
2. An interdisciplinary executive committee comprised of voting members which will:
  - a. elect a chair and vice-chair who will preside over meetings of the executive committee and general coalition membership meetings; and
  - b. set the agenda for coalition meetings.
3. Sub-committees and workgroups as are requested by members or individuals and organized under the umbrella of the coalition. These sub-committees and workgroups may exist and function temporarily or long-term, as needed.

## REGION 3 HEALTHCARE PREPAREDNESS COALITION BYLAWS

### **I. MEMBERSHIP**

#### **A. Coalition Membership**

Membership to the coalition is open to all Region 3 healthcare organizations and jurisdictions that agree to work collaboratively on emergency preparedness and response activities.

1. Member organizations will assign one to three representatives to attend Coalition meetings. The representative(s) should have the authority to represent and speak on behalf of the organization.
2. Organization representatives are eligible to fill elective Coalition positions.
3. If an individual representing an organization withdraws from participation, the member organization will appoint a new representative within 90 days.
4. Individuals may represent more than one member organization, but must clearly be acting in the interests of each represented organization independently.
5. If there is uncertainty as to whether an organization is a "Region 3 health care organization or jurisdiction" majority vote by Active Coalition Members will determine.
6. **Active Coalition Members** are those coalition members who have established voting rights as in Section III B.
7. **Inactive Coalition Members** are those coalition members who have failed to establish voting rights per Section III B.

#### **B. Partner Organizations Membership**

Partner Organizations will be non-voting members. Partner Organizations will assign one to three representatives to attend Coalition meetings. Partner Organizations are as follows and may be changed from time to time by updating these bylaws.

1. *Washington State Department of Health (WA DOH)*
2. *Region 3 Public Health Preparedness Council*
3. *West Region EMS and Trauma Care Council (WREMS)*
4. *Region 3 Homeland Security*
5. *Washington State Hospital Association*
6. *Washington Association of Community & Migrant Health Centers*

#### **C. Invited Non-Members**

Region 3 collaborating organizations which are deemed not eligible for membership under Section I A 5 may nevertheless be invited to attend coalition meetings and activities by vote of the membership. Such invited organizations may fully engage in coalition discussions and other activities, but shall have no vote.

#### **D. Membership Responsibilities:**

1. Provide representation at coalition meetings and activities and ensure attendance

2. Participate in collaborative regional preparedness planning
  - a. Set priorities
  - b. Participate in the development of surge capacity plans, inter organizational agreements, and collaborative emergency response plans.
3. Contribute to meeting coalition priorities, goals, and contractual deliverables
4. Vote on questions placed before the membership
5. Respond to regional emergencies and disasters in collaboration with other members

#### **E. Membership Roster**

A roster of member organizations will be maintained and updated from quarter to quarter.

1. The roster will be published with the agenda of each Coalition meeting
2. Each organization will be listed as appropriate as:
  - a. Active Coalition Member
  - b. In-active Coalition Member
  - c. Partner Organization Member
  - d. Invited Non-Member
3. The roster may include, but does not necessarily require inclusion of representative's names

#### **F. Membership Resignation**

Resignation must be submitted in writing to the coalition.

## **II. MEETINGS**

#### **A. Scheduling**

Coalition meetings will be scheduled at least quarterly. Written notice and agendas for all meetings of the membership shall be transmitted at least 5 working days in advance of the meetings.

#### **B. Venue**

Meetings will be held at locations convenient for members. Electronic ("Virtual") meetings are allowed.

#### **C. Attendance**

Meetings may be attended in person, by conference call or by other electronic means.

#### **D. Emergency meetings**

Emergency meetings may be convened at the request of the Coalition Chair provided that written notice is given each member at least 5 working days prior to the proposed meeting stipulating the time, place and objective of the meeting. No business may be transacted at an emergency meeting except that specified in the notice.

#### **E. Special Votes**

The Coalition may hold special votes by email or conference call. When such votes are conducted, there shall be a reasonable opportunity (five business days) for all members to have input prior to the vote. Voting shall be determined by a simple majority of a quorum of Active Coalition Members.

#### **F: Quorum**

Fifty percent of **Active Coalition Members** is a quorum.

#### **G: Conducting Business**

1. A quorum is necessary to conduct official Coalition business at a meeting.
2. Actions in a meeting shall be determined by a simple majority vote (excepting bylaw changes see section VI).
3. If a quorum is not present at a meeting, business will take place under the condition that any motions that are put forth to a vote will be presented to absent Active Coalition Members via email in order to receive a quorum vote. A reasonable amount of time will be allowed for receipt of absentee votes, not to exceed five business days from the date of the meeting. If a quorum is not obtained the motion fails.

### **III. VOTING**

#### **A. Votes**

1. Each member organization will have one vote.
2. Proxy voting is not allowed.

#### **B. Voting Eligibility:**

1. Voting is restricted to **Active Coalition Members**.
2. Attendance by a representative of the organization at two (2) of the last three (3) meetings (excluding emergency meetings) defines Active Coalition Members with the right to vote.

### **IV. LEADERSHIP**

#### **A. Executive Committee**

An interdisciplinary executive committee comprised of the representatives of five Active Coalition Members will be formed.

##### **1. Election**

- a. To be eligible to stand for election to the executive committee an individual must have attended 2 of the last 3 Coalition meetings.
- b. Elections for membership to the executive committee will occur during the last meeting of the fiscal year.
- c. Any new vacancies on the executive committee will be filled as soon as possible by vote of the consortium members.
- d. The current executive committee may place nomination(s) for vacant position(s) on the agenda of the last meeting of the fiscal year for action by the membership
- e. Nominations from the floor to stand for executive committee may be made by Active Coalition Members during the last meeting of the fiscal year.
- f. Nominations should be made in a fashion to maintain the multidisciplinary composition of the executive committee
- g. Executive committee members will serve for two years. (However, the first election will designate two positions that will serve for only one year in order that subsequent terms will be staggered)



- h. Special election may be called at any meeting to fill prematurely vacated executive committee position(s)
- i. There is no limit to the number of successive terms an executive committee member may serve.

## **2. Duties**

- a. Chose a Coalition Chair and Vice Chair from their number
- b. Review and approve meeting agendas
- c. Monitor Coalition projects and contract deliverables
- d. Support and advise the Executive Director

## **3. Decision Making**

- a. Decisions of the executive committee will be made by consensus
- b. If no consensus can be reached then such question will be deferred to the next meeting of the Coalition

## **B. Coalition Chair**

- 1. Chosen for a one year term for each calendar fiscal year from the membership of the executive committee by the executive committee.
- 2. Chairs Executive Committee and Coalition Meetings
- 3. Works closely with the Executive Director on current issues concerning the Coalition.
- 4. Available to the membership for information exchange concerning the Coalition
- 5. Acts in the general interests of the Coalition and its membership
- 6. Assumes additional duties from time to time and as appropriate to facilitate the function of the Coalition
- 7. The chair shall also serve as the official representative and spokesperson of the Coalition

## **C. Coalition Vice Chair**

- 1. Chosen for a one year term for each calendar year from the membership of the executive committee by the executive committee.
- 2. Acts for the Chair in his/her absence.

## **D. Coalition Executive Director**

- 1. Hired or Contracted by the Coalition
- 2. Responsible for management, day to day operations, and administrative support of the Coalition
- 3. May act under authority of the Chair as the designated representative and spokesperson of the Coalition.

## **V. STANDING COMMITTEES**

- 1. Region 3 Healthcare Preparedness Coalition: Hospital Preparedness Committee
- 2. Region 3 Healthcare Preparedness Coalition: Exercise Planning Committee

## **VI. AMENDING THE BYLAWS**

Amendment of these bylaws may take place at any meeting of the Coalition by a two-thirds majority vote of all Active Coalition Members *provided a copy of such proposed amendment(s) are distributed at least thirty (30) days in advance of such meeting, and attached to the written notice for that meeting.* If two thirds of all Active Coalition Members are not present at the Coalition meeting where such action is initiated, then the polling may be completed by email within 30 days.

## **VII. PARLIMENTARY PROCEDURE**

Roberts Rules of Order, (10<sup>th</sup> Edition) will be used to guide the conduct of any Coalition meeting.

## **VIII. LEGAL DISCLAIMER**

### **Indemnification and Limits of Liability**

*This Charter and Bylaws shall not supersede any existing mutual aid agreement or agreements.*

*This Charter and Bylaws shall not be interpreted or construed to create an association, joint venture separate legal entity or partnership among the member bodies or to impose any partnership obligation or liability upon any Health Jurisdiction. Further, no member shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other member body.*

*Any member shall not be required under this Charter to indemnify, hold harmless and defend any other member from any claim, loss, harm, liability, damage, cost or expense caused by or resulting from the activities of any Coalition officers, employees, or agents acting in bad faith or performing activities beyond the scope of their duties. In the event of any liability, claim, demand, action or proceeding, of whatever kind or nature arising out of rendering of Emergency Assistance defined through this Charter, the member agrees to indemnify, hold harmless, and defend, to the fullest extent of the law, each signatory to this Charter, whose only involvement in the transaction or occurrence which is the subject of such claim, action, demand, or other proceeding, is the execution and approval of this Charter.*

**APPROVAL OF CHARTER and BYLAWS: The Charter and Bylaws are adopted by a vote of the Region 3 Healthcare Preparedness Coalition membership.**

**Date Approved: September 10, 2010**  
**Revised 5/11/12 – Approved 6/12**



# ***Healthcare Coalition Charter***

## **Healthcare Coalition (HCC)**

The Region 1 Healthcare Coalition is a partnership of healthcare agencies, providers, and community partners working together to promote, consolidate, and coordinate a unified response to emergencies affecting the region.

## **Mission/Purpose**

The Region 1 Healthcare Coalition endeavors to develop and promote the emergency preparedness and response capabilities of Region 1 healthcare entities by:

- Strengthening medical surge capacity and capabilities
- Building relationships and partnerships
- Facilitating communication, information and resource sharing
- Maximizing movement and utilization of existing resources
- Coordinating training, drills, and exercises

## **Roles of Coalition Facilitation/Sponsors**

- **Washington State Department of Health/Washington State Hospital Association:**  
Provides technical support liaisons to assist regions with coalition efforts.
- **Region 1 Public Health Emergency Preparedness & Response:**  
Provides insight, policy guidance, and leadership through meeting participation, planning support and communications to promote, attain and sustain Public Health.
- **North Region EMS and Trauma Care Council:**  
Provides support to the Region 1 Healthcare Coalition and organizational services to advance and facilitate the delivery of emergency medical services by coordinating and advising the efforts through lead administrative support, and facilitation of coalition meetings and deliverables.
- **Member/Member Organizations:**  
Provide representation at coalition meetings and activities, develop strategies and contribute to achieving established coalition priorities and goals.

## **Coalition Time Frame**

Ongoing, beginning December 1, 2006, until disbanded by a vote of the membership.

## **Coalition Membership**

Membership: Membership in the coalition is open to all Region 1 organizations or entities that agree to work collaboratively on healthcare emergency preparedness and response activities. Membership includes but is not limited to all Region 1:

- Hospitals
- Emergency Management Agencies
- Medical Reserve Corps
- Tribal Nations
- Local Public Health
- Clinics
- EMS Agencies
- Private EMS Agencies
- ESF 8/6 Supporting Agencies
- Community & Migrant Health Centers
- Home Health/Long Term Care
- Private Physician Groups
- Mental Health
- Medical Examiners/Coroners
- Fire Departments
- Law Enforcement Agencies
- ARES/RACES/ACS

Member organizations will assign a representative, who will represent and speak on behalf of the organization.

Member Resignation: If an individual representing an organization withdraws from participation, a new representative should be appointed within 90 days.

### Membership responsibilities/expectations:

- Designate a representative and alternates to assure ongoing participation in the coalition.
- Attend regularly scheduled meetings.
- Educate and inform member organizations on coalition activities.
- Participate in establishing priorities for the coalition.
- Participate in the development of surge capacity plans, agreements and emergency preparedness and response plans.
- Participate in coalition sponsored training exercises and drills.
- Follow Roberts Rules of Order, (10<sup>th</sup> Edition) to guide the conduct of any Region 1 Healthcare Coalition meeting.

## **Voting**

Voting membership: Each member organization will have one vote. A member may represent more than one organization however they will only have one vote per agency. A proxy may be selected for a voting member.

Proxy Vote: If a member is unable to attend a scheduled meeting, they may transfer their vote to a proxy.

Quorum: At all meetings of the Coalition, a simple majority of the members shall constitute a quorum.

Simple Majority: 51% of those present at the meeting. Five of the nine hospitals must be represented at the meeting for vote.

## **Conducting Coalition Business**

A quorum is necessary to conduct official Coalition business at a meeting. Actions in a meeting shall be determined by a simple majority vote of members present except for the changing of rules which would require a simple majority of all members by mail or email with 30 days notice.

The Coalition may hold special votes by email or conference call. When such votes are conducted, there shall be a reasonable opportunity of five (5) business days for all members to have input prior to the vote. Voting shall be determined by a simple majority of all eligible members.

If a quorum is not present at a meeting, business will take place under the condition that any motions put forth to a vote will be presented to absent voting representatives via email in order to receive a quorum. A reasonable amount of time will be allowed for receipt of absentee votes, not to exceed five (5) business days from the date of the meeting. If a quorum is not obtained, the motion fails.

## **Meetings**

Coalition meetings will be scheduled quarterly at a minimum. Written notice and agendas for all meetings of the membership shall be transmitted at least five (5) working days in advance of the meetings.

Emergency meetings may be convened at the request of the Coalition Chair provided that written notice is given each member at least five (5) working days prior to the proposed meeting stipulating the time, place, and objective of the meeting. No business may be transacted at a special meeting except that specified in the notice.

## **Coalition Officers and Committee Roles**

Chair: The Chair shall provide the direction and leadership for the Healthcare Coalition.



He/She shall act as chair over all Coalition meetings and assist in developing agendas and minutes of the Coalition meetings. The chair or designee shall also serve as the official representative and spokesperson of the Coalition; and act as the liaison to the Region 1 Homeland Security Council and other support foundations and agencies.

Vice Chair(s): The Vice Chair(s) shall perform the duties of the Chairperson in their absence. The Vice Chair(s) may also serve as the liaison to outside agencies and perform other duties as needed at the direction of the chair.

At the end of the calendar year, the Committee will accept nominations for new officers. The current chair and vice chair(s) may be nominated for re-election. Elections will be held in January of every other calendar year to take effect at the beginning of the fiscal year July 1st. During the interim period, the current officers and officers elect will work together for a smooth transition of duties.

The Coalition will establish committees to carry out its activities.

**Executive Steering Committee:** An Executive Council will provide the leadership to the Coalition. The Executive Council membership will be comprised of the elected chairs and co-chair(s) of the Hospital Planning Committee and Healthcare Coalition, elected vice chair(s), Public Health representative, North Region EMS representative, and the WSHA representative.

### **Healthcare Coalition Standing Committees**

- 1 Region 1 Hospital Planning Committee

### **Healthcare Coalition Sub-committees**

- 2 Alternate Care Facilities
- 3 Evacuation/Surge
- 4 Communications
- 5 Training & Exercise
- 6 Mass Fatality
- 7 Disaster Medical Coordination Center
- 8 Special Adhoc as needed

***APPROVAL OF CHARTER: The Charter is adopted by a vote of the coalition membership. This Charter may be amended by a simple majority of the voting membership present at a regular or special meeting of the Council, provided a copy of such proposed amendment(s) are distributed at least thirty (30) days in advance of such meeting, and attached to the written notice for that meeting.***

**Date Charter Approved:** \_\_\_\_\_

**Date Charter Revision Approved:** \_\_\_\_\_

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KING COUNTY  
Healthcare  
Coalition

Prepare. Respond. Recover.

## Healthcare Coalition Executive Council

Meeting Notes – March 7, 2007

Swedish Medical Center Conference Room A

### **Council Members Present:**

Dr. Tony Woodward, Children's Hospital & Medical Center, Pam MacEwan, Group Health, Johnese Spisso, Harborview, Gayle Ward, Northwest Hospital & Medical Center, Joyce Jackson, Northwest Kidney Centers, Dianna Reeley, Overlake Hospital Medical Center, Anita Geving, Polyclinic, Cal Knight, Swedish Medical Center, Paul Hayes, Valley Medical Center, Patty Mulhern, Visiting Nurses Services

### **Also Present:**

Dr. David Fleming, Public Health - Seattle & King County, Dorothy Teeter, Public Health - Seattle & King County, Chris Martin, Harborview Medical Center, Peter Rigby, Northwest Hospital & Medical Center, Michael Loehr, Public Health – Seattle & King County

### **Staff Present:**

Joe Cropley, Washington Poison Center, Richard Marks, Consultant, Cynthia Dold, Public Health - Seattle & King County, Dr. Jeff Duchin, Public Health - Seattle & King County, Dr. Lewis Robinson, Public Health - Seattle & King County, Lydia Ortega, Public Health - Seattle & King County, Onora Lien, Public Health - Seattle & King County

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### **Introductions**

Johnese Spisso called the meeting to order at 3:00pm and welcomed members of the newly formed King County Healthcare Coalition Executive Council and the new Health Director of Public Health Seattle and King County, Dr. David Fleming.

### **Approval of Preparedness and Response Roles and Coalition Work Plan**

Richard Marks reviewed a PowerPoint presentation with the Council on the preparedness and response roles of the Healthcare Coalition and the Executive Council. He also reviewed the Work Plan for the Coalition and 2007 priorities.

**ACTION: The Council approved the Healthcare Coalition and Executive Council roles and work plan.**

### **Approval of Executive Council Officers,**

Richard Marks presented the proposed chair and vice-chair to the Council - Chair: Johnese Spisso, Harborview Medical Center; Vice Chair: David Grossman, MD, Group Health.

**ACTION: The Council approved Johnese Spisso as Chair and Dr. David Grossman as Vice-Chair.**

### **Regional Response Report**

Michael Loehr, the Preparedness Manager for Public Health Seattle and King County, presented an overview of the windstorm response and lessons learned. The Regional Medical Resource Center was activated for the first time during the windstorm response to track and acquire resources for nursing homes and hospitals and to collect and coordinate information. An area for improvement is the need for a comprehensive management information system to track healthcare system resources and needs in real time. There is also a need for the RMRC to improve coordination with local and zone Emergency Operation Centers.

The Public Health Communications Team and the Vulnerable Populations Action Team were dispatched to educate immigrant communities about the dangers of carbon monoxide. Areas for improvement include strengthening the link to all Healthcare Coalition members and partners and developing a more focused communications plan that targets strategic outreach to immigrant communities and links them with healthcare providers. Health and human service needs have a direct impact on hospitals and other parts of the healthcare system. Areas for improvement include informing healthcare providers about the location of medical and non-medical shelters to serve people who come to hospitals because they are “safe havens”.

### **Regional Response Report**

Joe Cropley, Washington Poison Center, presented an update on the Puget Sound Call Center Coordination project. The goal of the project is to create a network of call centers that can provide medical phone triage and disseminate up-to-date public health information in King, Pierce, and Snohomish Counties during a disaster. The call center project was suggested by the Healthcare Coalition Steering Committee and the Ambulatory Care Workgroup. Council members commented that the region should consider the likely demand for information on West Nile Virus this summer. In addition, the project should coordinate its efforts with the Centers for Disease Control and the media. Also, the project should address the possibility that residents of other communities may try to access the service if it is available through a 1-800 number.

### **New Issues**

#### **Emergency Department Saturation**

Johnese Spisso discussed the challenges that have been experienced during the ice storms and the windstorm related to hospitals not complying with the regional ED Saturation Policy. The Policy restricts the amount of time that Hospital Emergency Departments can break from receiving patients who are on Basic Life Support (BLS). Hospital ED's can never be on Advanced Life Support (ALS) divert. After review, several hospitals were placing themselves on “ED Saturation” for over 150 hours a week during the snowstorm of November 2006. Other hospitals were going on ALS divert during the response as well. Hospitals have been operating at full capacity since the snowstorm in November of 2006. During the windstorm in December, the situation reached a critical mass. The Council agreed that gathering data over a 6 month period will be critical for addressing the issue.

**ACTION: Dr. Lewis Robinson will work with Public Health and Harborview Medical Center leaders to develop a briefing on the issue to present to the Council in June.**

#### **Human Resources**

The Council discussed staffing shortages that posed a significant challenge to healthcare facilities during the November ice storm and the December windstorm in 2006. Several area hospitals addressed this problem by proactively arranging to transport staff directly to work. In the future, hospitals may have to adjust staffing ratios for intensive care and acute care during emergencies to serve patient demand. In order to address the staffing challenges that would occur in a pandemic or other medical catastrophe, hospitals need to work closely with their employees and their bargaining representatives.

**ACTION: Richard Marks will work with Council leaders to develop a strategy to engage unions and bargaining units in preparedness planning and will report back to the Council in June.**

### **Adjournment**

Johnese Spisso adjourned the meeting at 5:00pm.

<b>Future Meeting Dates:</b>	June 4, 2007	11.00 – 1.00 pm
	September 14, 2007	8.30 – 10.30 am
	November 29, 2007	2.00 – 4.00 pm

Dear Colleague,

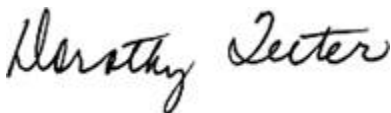
We are writing to invite you to an important breakfast meeting of local hospital and major medical group leaders to discuss the formation of a King County Healthcare Emergency Coalition. The Coalition is intended to enhance coordination and communication within the healthcare community in responding to the health effects of a major emergency or disaster. The meeting will be held on DATE at TIME, at Location X. Please RSVP to Person X at (XXX) XXX-XXXX or via email at EMAIL ADDRESS by DATE.

If you are not able to attend, we ask that you please ensure that an executive level designee attends to represent you. Space is limited and attendance is by invitation only.

In light of Hurricane Katrina, which devastated the health care infrastructure in New Orleans, and with growing concerns about the possibility of a worldwide influenza pandemic, we feel that our healthcare community must take greater steps to prepare for public health disasters. We are proposing to form a Healthcare Emergency Coalition that can increase our health system's capacity to respond to a major disaster through collaborative planning, timely communication and information sharing, and effective resource coordination.

At the meeting, we will provide the latest information about health-related emergency preparedness planning in our community and we will present a proposal for strengthening the health system's ability to respond to emergencies. Please feel free to contact us if you have any questions about the meeting. We look forward to working with you and your team to create a truly coordinated, effective health system response to any catastrophe that could affect the health of the residents of King County.

Sincerely,



Dorothy Teeter, MHA  
Interim Director and Health Officer  
Public Health-Seattle & King County



Leo Greenawalt  
President and CEO  
Washington State Hospital Association



Dear Colleagues,

Thank you for the outstanding attendance at the Healthcare Coalition meeting on Thursday, November 3rd. Twenty-two healthcare organizations participated in the meeting, and the attendees overwhelmingly supported the proposal to create a King County Healthcare Emergency Coalition. The Coalition would serve to strengthen coordination and communications among a broad range of healthcare organizations in preparing for and responding to major emergencies and disasters.

We need your feedback on the Coalition proposal, which is described in the attachment. Specifically, we need the following information:

1. Confirm your organization's commitment to participate in the proposed Coalition or if you need more information before you can decide.
2. Any comments, questions, concerns, suggestions about the Coalition proposal.
3. The name and contact information for an executive-level representative to serve on the Coalition's Executive Advisory Body.

We will be contacting you in the near future to identify management and clinical experts from your organization who would participate in Coalition work groups that will develop detailed plans for the health system's response to pandemic influenza and other emergencies. Also, we are planning to hold several additional briefings for executives and organizations who could not attend the initial meeting.

We believe that it is important to move forward expeditiously to develop the Coalition and to prepare our health system to respond to emerging threats such as a pandemic outbreak. We would appreciate your feedback and response to this e-mail by November 23rd. If you would like to discuss the Coalition proposal, please feel free to contact me at (XXX) XXX-XXXX.

Sincerely,

Dorothy Teeter  
Interim Director and Health Officer  
Public Health - Seattle & King County



## POSITION PAPER

# Working to **ASSEMBLE** Effective Healthcare Coalitions

By: Bill Halstead, MPA, CEM; Jeffrey Schlegelmilch, MPH, MEP;  
Eileen Blake, MPH; James Paturas, CEM, CBCP, FACCP  
Yale New Haven Center for Emergency Preparedness and Disaster Response

## Introduction

Recent updates to the Healthcare Preparedness Capabilities issued by United States Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS-ASPR) place special emphasis on the development of healthcare coalitions. Coalitions are designed to create a comprehensive and resilient response to catastrophic health events via collaborative partnerships and formal harmonization of activities among healthcare organizations, public health departments, emergency management and response agencies, as well as other entities supporting Emergency Support Function #8 (ESF-8).



“Healthcare coalitions are defined as a ‘single functional entity’ of healthcare facilities and other healthcare assets to organize and implement the mitigation, preparedness, response, and recovery actions of medical and healthcare providers in a jurisdiction’s healthcare system.”[1] Working as one cohesive unit, a healthcare coalition can support jurisdictions in mitigating the potential effects of a disaster or emergency. This concept expands traditional ESF-8 structure to include representatives of other agencies that have a direct role in an emergency and are necessary for a successful response.

...every coalition will differ with respect to the number and types of organizations of which it is composed.

Healthcare Preparedness Capability, Function #1 – *Healthcare System Preparedness* specifically addresses the need for coalitions. Task #1 of this function states that planners will “Form a collaborative preparedness planning group that provides integration, coordination, and organization for the purpose of regional healthcare preparedness activities and response coordination”. This capability is linked directly to the Public Health Emergency Preparedness (PHEP) Capability #1, *Community Preparedness: Function 2, Build community partnerships to support health preparedness, and Function 3, Engage with community organizations to foster public health, medical, and mental/behavioral health social networks* (July 2011). [2]

## The Challenge: Healthcare Coalition Development and Support

The challenge to state and local preparedness coordinators is the lack of a prescribed paradigm for establishing and managing the ideal healthcare coalition. Additionally, every coalition will differ with respect to the number and types of organizations of which it is composed. Existing relationships among response agencies, geographic location, and the presence of shared hazards and vulnerabilities will all contribute to the distinctiveness of these coalitions.

Health preparedness coordinators can choose to define their coalition by geographic lines (county, municipality), population numbers and distribution, existing regional boundaries, or federally defined lines (e.g., Urban Area Security Initiative areas or Metropolitan Statistical Areas).

The flexibility of definition may also be a challenge. Although it gives the freedom to choose where and how a coalition will exist, it can also become a daunting task to determine what an appropriate coalition coverage area is and what to do when pre-defined regions are not consistent across planning initiatives.

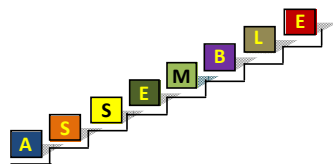
Additionally, health preparedness coordinators are dealing with reduced budgets and an increased strain on an already stretched workforce. The alignment of grant requirements is providing increased access to other preparedness funding sources as well as providing more flexibility in inter-disciplinary preparedness initiatives. However, in the near term this is creating an additional burden on health preparedness coordinators as they learn to work with these other funding streams and planning structures that are also struggling with reduced funding.

Using a manageable stepped process for implementation and management of healthcare coalitions can facilitate the establishment of a functioning healthcare coalition without causing an undue burden on personnel and resources.

## The ASSEMBLE Process

YNH-CEPDR has worked for years with the Connecticut

Department of Public Health to support the development and sustainment of healthcare coalitions. In establishing a process for doing this,



YNH-CEPDR has successfully applied this process to support coalitions in other parts of the country with different political and planning structures through a process called **ASSEMBLE**. The ASSEMBLE process is a flexible approach that can be adapted to any jurisdiction and contains eight core components.

**Area of authority** – A critical and often complicated step for a healthcare coalition is determining the area that it will serve. As there may be multiple regional boundaries to consider, this selection involves evaluating the most appropriate areas based on legal authority, funding availability, and existing planning systems. These may include Urban Area Security Initiative (UASI) areas, regional governance structures, county lines, municipal lines, or other such dividers.

### Secure agreement

The next step is to make certain that community leaders and agency stakeholders are willing and able to engage in this process.



Chief elected officials are also encouraged to permit their representatives to work with the group and delegate the authority for their representatives to make decisions on behalf of the municipality. To ensure that the leaders understand the benefits of forming a coalition, planners should explain the many benefits of participation. These may include the potential to fulfill grant deliverables, receive expert advice and planning tools, and build pre-event relationships.

Creating an Executive Order or other document detailing how a jurisdiction will participate in this process can provide the necessary mandate and expectations for community leaders regarding their level of participation. Other items for consideration include reimbursement of

personnel time and travel costs if not already covered by their full-time duties.

### **Seek representation –**

Using a “whole community” approach, key partnerships are identified within the jurisdiction and brought together to create a cohesive planning team. With the ever-increasing potential for catastrophic emergencies, it is essential that organizations have pre-established relationships and stand ready to jointly respond to any event. Healthcare coalitions must include organizations beyond the healthcare sector. Emergency managers, first responders, non-profit organizations, private sector vendors, and others will be critical to the success of an emergency response. Therefore, they should have a voice in the planning stages. Individuals should participate fully in and contribute to the planning team; utilizing existing planning structures and relationships helps to facilitate this. They should also hold the authority to make decisions on behalf of their organization. Without this authority, the process will be slowed by having to return and obtain permission for specific decisions.



*...existing plans and procedures will serve as an important foundation for the coalition to build off of. Expansion of current documents may be easier than creating an entirely new document.*

Initially, some representatives may be hesitant to join the coalition because of the time commitment. In many cases, planners and other staff may hold multiple positions or duties, and adding another meeting can be burdensome. In these cases, the benefits of the coalition should be stressed. An example of how a coalition can be extremely beneficial is the planning collaboration that will occur from the group.

### **Examine existing plans –**

As with any planning project, it is necessary to invest some time to determine what is currently in place in the area that is applicable to the coalition. When bringing in multiple organizations that each has their own emergency plan and processes, it is necessary to be aware of potential integration problems with anything the coalition develops. Some plan sections from stakeholder plans that will need to be in alignment for coalition coordination includes command and control, information coordination, and communication sections, among others. Additionally, existing plans and procedures will serve as an important foundation for the coalition work as mutual coordination structures emerge from existing stakeholder plans. Expansion on current documents may be easier than creating an entirely new document. Reviewing current hazard vulnerability analyses and gap analyses is a recommended starting point for development.



**Meet –** With all of the initial planning pieces in place, the team must come together and begin working towards their goals. A regular meeting

schedule must be established so representatives can plan for attendance at future meetings. Team co-chairs and other leadership positions should be elected or delegated. Ideally, one co-chairperson should be from a healthcare organization, and one should be from an agency that represents local or state public health. This will allow a fair and equitable voice in the coalition decision making. If the coalition's projects are large, sub-committees or work groups may be created to assist in dividing the work and ensuring that no one is carrying a disproportionate burden. Examples of sub-committees or work groups include planning,

legal/regulatory issues, staffing, resource sharing, communications coordination, and any others that are integral to the area's health hazards.

**Build doctrine and plans** – The creation/adaptation of policies, procedures, by-laws, and other documents will facilitate the process for how this newly formed team will collectively make their community better prepared to plan for, respond to, and recover from public health emergencies and other large-scale disasters. Examples of these documents include:



- Core mission statement and goals
- By-laws or charter
- Planning schedules
- Training and exercise schedules
- Policies, procedures, and guidelines
- Organizational charts
- Planning objectives

Additional plans such as operational and coordination plans are then created to outline the roles and responsibilities of the coalition during an emergency event. Some things to consider for plans include notifications, resource sharing and acquiring, coordination roles, integration with state and federal resources, as well as assimilation into local or regional Emergency Operations Centers (EOC). Ultimately these plans are also integrated with other local emergency operations and public health emergency plans.

**Leverage resources** – Whole community preparedness involves leveraging current resources and initiatives that facilitate planning, training, and exercise projects. Many programs reward regional collaboration and as such may fund certain projects. Exercises may fulfill current grant deliverables for organizations (e.g., FEMA

grants, HHS grants, CDC grants). As such, one combined exercise involving multiple jurisdictions can help numerous entities meet their individual requirements without duplicating effort. Planners from each organization are encouraged to come together to write a plan that will be representative of all groups involved and not take away from any one person's duties unnecessarily. With dwindling funds and resources, it is necessary to remain creative to secure needed resources for preparedness.

**Engage** – The final step in any planning team process is implementing strategies to keep the group engaged. As time goes on, representatives may put this work aside to focus on other competing priorities. The risk with this will be that the team will not be a cohesive group when they are needed most. Keeping participants engaged through yearly training and meeting schedules can

*The tools gained from coalitions, such as plan templates, trainings, and exercises, will also help to ease the planning burden on individual communities and their resources.*

allow people to plan to attend these functions. Outputs such as plans and exercises will help illustrate the usefulness of the group and will encourage decision makers to continue their support. The tools gained from coalitions, such as plan templates, trainings, and exercises, will also help to ease the planning burden on individual communities and their resources.

### Partnering with YNH-CEPDR

Established in 2002 as part of the Yale New Haven Health



System, the Yale New Haven Center for Emergency Preparedness and Disaster Response (YNH-CEPDR) is committed to developing and delivering services that advance healthcare planning, preparedness, response, and recovery for emergency events and disasters through collaborative partnerships and coordinated programs.



With a staff of over 50 subject matter experts in areas including hospital and public health, emergency management, emergency and disaster medicine, education and training, and drills and exercises, YNH-CEPDR is dedicated to developing and providing high-quality products and services. YNH-CEPDR has earned a solid reputation as a national and international leader in health and medical disaster preparedness, hazard mitigation, continuity of operations planning, and emergency response and recovery. ***YNH-CEPDR has the knowledge and experience to assist public health agencies and healthcare organizations in creating effective healthcare coalitions.***

YNH-CEPDR's collective subject matter experts can further assist by providing specific emergency and strategic plans, gap analysis, capabilities reports, plan templates, exercises, and training that will take the burden off of already over-tasked team members. This will allow the planning team to help enhance their capabilities and bring them to the next level while not draining current resources. Integration of YNH-CEPDR planning, training, and exercise services within coalition activities will allow states to maximize limited resources for achievement of HPP/PHEP capabilities.

Additionally, as part of a world-renowned health system, our methodology has been tested and validated in response to real-world events. Due to the diversity of our health system, which includes an academic medical center, a large urban area hospital, a suburban hospital, a children's hospital, a psychiatric facility, a cancer center, and multiple community facilities and organizations, we have demonstrated how our services have been implemented in multiple healthcare environments.

## References

1. HHS/ASPR. *From Hospitals to Healthcare Coalitions: Transforming Health Preparedness and Response in Our Communities*. 2009; Available from: <http://www.phe.gov/Preparedness/planning/hpp/Documents/hpp-healthcare-coalitions.pdf>.
2. HHS/ASPR. *Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*. 2012; Available from: <http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/capabilities.pdf>.

For additional information about this service, please contact [Eileen.Blake@ynhh.org](mailto:Eileen.Blake@ynhh.org), (203) 688-5000, [www.ynhhs.org/cepdr](http://www.ynhhs.org/cepdr).

Meeting Date	Location	Attendees	Agenda Items
August 16, 2012 11:00 AM to 4:00 PM	Hadley Room 2 Hays Medical Center		
September 26, 2012 12:00 PM to 4:00 PM	Hadley Room 2 Hays Medical Center		
December 5, 2013	Hadley Room 2 Hays Medical Center	Hospital Meeting 10:00 AM to 12:30 PM Coalition Meeting 1:00 PM to 4:00 PM	Development of Coalition
January 23, 2013	Hadley Room 3 Hays Medical Center	Hospital Meeting 12:00 PM to 3:00 PM	Evacuation/Shelter in Place (possible guest speaker)
March 27, 2013	Hadley Room 3 Hays Medical Center	Hospital Meeting 10:00 AM to 12:30 PM Coalition Meeting 1:00 PM to 4:00 PM	TBD
April 18, 2013	Regional Tabletop Exercise (Tabletop to be conducted locally to eliminate travel)	All Coalition partners, ESF 8 Partners to be invited to participate locally.	Capabilities Exercised: 3- Emergency Ops Coordination 6- Information Sharing 10- Medical Surge
May 22, 2013	Hadley Room 3	Hospital Meeting 10:00 AM to 3:00 PM	ACS Trailer Work Day
June 26, 2012	Hadley Room 2	Hospital Meeting 10:00 AM to 12:30 PM Coalition Meeting 1:00 PM to 4:00 PM	TBD